**Youth Mentoring Service**

The Altering Group

[www.thealteringgroup.co.uk](http://www.thealteringgroup.co.uk)

020 3538 5877

 contact@thealteringgroup.co.uk

**Professional Referral Form**

**\***Mandatory fields – please note we may be unable to accept referrals without all mandatory information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Referrer Details** | | | | | |
| **\*Client consented to referral: Yes  No** | | | | **\*Date of referral:** | |
| **\*Referrer name:** | | | | **\*Referrer role:** | |
| **\*Referrer organisation:** | | | | **\*Organisation address:** | |
| **Referrer telephone:** | | | | **\*Referrer email:** | |
| **Young Person’s Details** | | | | | |
| **\*First name:** | | **\*Surname:** | | **\*Address:**  **\*Postcode:** | |
| **Preferred pronouns:** | | | | **\*DOB:** | |
| **Contact email:** | | | | **Contact number(s):** | |
| **Emergency contact name:** | | | | **Emergency contact relationship:** | |
| **Emergency contact number:** | | | | **Registered GP Surgery:** | |
| **GP Surgery Address:** | | | | **Education Setting:** | |
| **Demographic Information** | | | | | |
| **Gender:** | **Ethnicity:** | | **Sexuality:** | | **Religion:** |
| **\*Disability: Yes  No  Unknown** | | | **Disability (specify):** | | |
| **Access requirements:** | | | | | |
| **Referral Information** | | | | | |
| **Reason for referral & current challenges for Young Person:**  Please provide details of client’s current challenges, circumstances or concerns.  **Relevant history:**  Please include any significant diagnosis and history of difficulties.  **Current medication:**  **Any additional information:** | | | | | |
| **Please select all applicable challenges below for the Young Person:** | | | | | |
| **Ability to avoid dangers/hazards** | | | **Anger** | | |
| **Anxiety** | | | **Community linkage of services** | | |
| **Daily living skills** | | | **Depression** | | |
| **Grief** | | | **Housing** | | |
| **Hygiene** | | | **Impulsive behaviours** | | |
| **Juvenile justice/Court involvement** | | | **Life skills** | | |
| **Maintaining personal affairs** | | | **Medication education** | | |
| **Nutritional** | | | **Phobia/s** | | |
| **Safe living situation** | | | **School behaviour** | | |
| **Self-advocacy skills** | | | **Self harm** | | |
| **Separation issues** | | | **Social skills** | | |
| **Trauma** | | | **Truancy** | | |
| **Whole health/Wellness** | | | **Youth to young adult transition** | | |
| **Other:** | | | | | |
| **Other Service Involvement** | | | | | |
| **Is the client receiving any other support/services (list services):**  Please include all current services the client is open to.  **Is the client open to secondary care services (list services):** | | | | | |
| **Risk Information** | | | | | |
| **Any known risk concerns: Yes  No** | | | **Any known safeguarding concerns: Yes  No** | | |
| **Please provide information on any known risk/safeguarding concerns:**  **Measures in place to manage risk/safeguarding concerns:** | | | | | |